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## SI0216

### Death Investigation

The Police Service of Northern Ireland investigates suspicious and non-suspicious deaths on behalf of the Coroner to enable the Coroner's decision on the need for a post mortem examination and/or a Coroner's Inquest. This Service Instruction provides guidance on investigating deaths as an agent of HM Coroner.



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## 1. Introduction

The aim of this Instruction is to provide guidance into:

- The Investigation of Non-Suspicious and Suspicious Deaths;
- Stillbirth Guidance;
- The Investigation of Sudden Unexpected Deaths in Infants and Children under 2;
- The Investigation of Suspected Drug Related Deaths;
- The Removal, Retention and Use of Human Tissue.

References to Senior Investigating Officer (SIO) in this Instruction can be taken to refer to a Major Investigation Team SIO, a Fatal Road Traffic Collision (RTC) SIO or simply the senior officer at the scene.

This document should be read in conjunction with the Coroner's Best Practice Guide  
[http://Policenet/working\\_with\\_the\\_coroner.pdf](http://Policenet/working_with_the_coroner.pdf).

This Instruction is deemed to comply with the Human Rights Act and United Nations Convention on the Rights of the Child. It has been screened for Section 75 considerations and meets the organisation's integrity standards.

Every unexpected, unnatural, or questionable death should be reported to the Coroner who must be informed as soon as the Investigating Officer (IO) attends the scene. The Coroner's Office can be contacted on **0300 200 7811**.

The Police Service of Northern Ireland (PSNI) have responsibility under the Coroner's Act (Northern Ireland) 1959 to assist the Coroner in establishing how, when and where the deceased came about their death. In practice, this necessitates police undertaking initial investigations to enable the Coroner's decision on the need for a post mortem (PM) examination and/or a Coroner's Inquest. The police also have responsibility for providing sufficient initial investigation to enable the pathologist to understand the circumstances of the death.

A sudden death, whether in suspicious or non-suspicious circumstances, involves the loss of a loved one and will be a shock to the bereaved family. They will be experiencing a variety of emotions and the presence of uniformed police officers may be upsetting for them.

When introducing yourself to a bereaved family, clarify that you are acting on behalf of the Coroner and what you require from them in terms of medical history, statements etc. Inform them that a

Coroners Liaison Officer (CLO) from the Coroner's Service will be in touch with them and that they, not the police, will update them on the post mortem and arrangements for returning the deceased to them. The CLO will also provide them with information on bereavement services and support.

Although you are acting as an agent of the Coroner when investigating a death, you are also a professional police officer who is governed by the Code of Ethics and Policing with the Community values.

Bear in mind that your conduct during an investigation on behalf of the Coroner impacts upon the public perception and professional image of the PSNI. As with any enquiry, decisions made in the course of your investigation should be recorded in your notebook and on the relevant OEL.

Please remember that if you attend a death and a Doctor signs a death certificate, you are simply required to advise the deceased's family that their chosen undertaker may now assist them. There will be no further police or Coronial involvement.

The following are the different types of death police investigate, **solely** as an agent for the Coroner:

- Non-suspicious deaths;
- Suicides i.e. where a person has taken their own life deliberately and there is no suspicion of involvement by another party;
- Fatal Road Traffic Collisions where the deceased was the only driver involved in the collision;

If a deceased person has not been seen (as a patient) by their Doctor within the 28 days preceding their death, a death certificate cannot be issued. Either the Coroner will register the death or direct that a post mortem examination be conducted.

Police have additional responsibilities in circumstances where it is possible that an offence has been committed in the circumstances surrounding the person's death.

In addition to providing information and evidence to enable the Coroner to fulfil their obligations, police have a responsibility to secure and preserve evidence of any criminal offence connected to the person's death. This includes homicide and deaths resulting from fatal road traffic collisions where a person other than the deceased may have committed an offence.

The following are the different types of death where police investigation, in addition to acting on behalf of the Coroner, will be necessary to secure and preserve evidence with a view to bringing those responsible for the death to justice:

- Fatal Road Traffic Collisions where the deceased person is not solely responsible for their death;
- Suspicious deaths, where the circumstances of the death raise suspicion that death may have occurred due to a criminal act. Such deaths will be investigated thoroughly until such time as the possibility of homicide or other criminal act is eliminated.

### **Investigating Sensitive/Complex Coroner's Cases**

Where a non-suspicious death occurs and the circumstances render it a complex or sensitive case, Senior Management in the relevant District should consider obtaining investigative assistance from a suitably trained and experienced investigator, if not an SIO.

Senior Management should ensure effective line management during the investigation and ensure regular reviews are conducted of the progress of the investigation.

When appointing an IO to a complex or sensitive non-suspicious death, managers should remember that a trained Family Liaison Officer (FLO) has a defined role as set out in the Authorised Professional Practice (APP) ACPO Family Liaison Officer Guidance 2008. It would not be suitable to assign them as IO in a complex or sensitive non-suspicious death.

## 2. The Investigation of Suspicious and Non-Suspicious Deaths

### Initial Response

The responsibility of the first officer at the scene of a death is to:

- Preserve life (summon medical assistance if appropriate);
- Task a doctor to pronounce death;

If there are no suspicious circumstances surrounding the death and a deceased's own doctor is not available, then the local on call, 'out of hours' doctor should be contacted. Contact Management Centres have details of 'out of hours' doctors.

- A Forensic Medical Officer (FMO) should be the only person contacted to pronounce death at the scene of a suspicious death (including a death following police contact). In these circumstances, full forensic protection should be worn by attending medical personnel and the body should be photographed prior to disturbance. If another medical professional has already verified life extinct at the scene of a suspicious death and the SIO is satisfied with this, there is no requirement to task an FMO;

- In cases of serious delay with the General Practitioner (GP) or out of hours doctor attending a non-suspicious death, an FMO should be tasked to save any further distress for the bereaved family;

- If you attend the death of a foreign national who is not registered with a GP in Northern Ireland (including tourists), task an FMO to pronounce death/verify life extinct. A GP will be unable to sign a death certificate where the deceased's medical history is not known. When appropriate, check the remains for an identification card which may assist when tracing a next of kin via the relevant embassy;

- Establish and maintain the scene in a suspicious death; The Service Instruction relating to Serious Crime Scenes should be adhered to;

- In the case of a Sudden and Unexpected Death of an Infant (SUDI) or a Child under 2, see [Chapter 5](#) of this instruction for further instruction;

- Make initial enquiries to ascertain the facts and circumstances surrounding the death. Ensure, where relevant, the Harassment, Domestic Abuse and Child Protection Registers are examined.

Verification of life extinct has traditionally been carried out by doctors, but it can be

carried out by any doctor, nurse or ambulance clinician who has had appropriate training. If an appropriately trained health professional is present at the time of death, they should pronounce life extinct. An officer attending any sudden death should ensure full details of attending paramedics/ambulance staff and doctor pronouncing life extinct are recorded prior to the staff leaving the scene;

- Ensure the death has been reported to the Coroner by telephoning **0300 200 7811**. A record of who contacted the Coroner and at what time must be entered on the OEL;
- In the case of an unexpected death of a child under 18 years of age where there are suspicious circumstances or any concern of a child protection nature, a referral should be made as soon as possible to the Health and Social Care (HSC) Trust or regional 'Out of Hours' service as per the 'Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland' ([Click here](#));
- Where circumstances warrant suspicion that death was unnatural, consideration should be given to any potential risk posed to the safety and well-being of others (e.g. children or vulnerable adults).

### Scene Preservation

Upon arrival at the scene of any death, a dynamic risk assessment should be undertaken. Where carbon monoxide/gas poisoning is suspected Northern Ireland Fire and Rescue Service should be tasked and all personnel should immediately leave any enclosed spaces/buildings.

If the death appears drug related, Officers should take precautions re sharps such as syringes.

As far as possible, the scene should not be disturbed until the facts surrounding the death have been established. The body should not be removed until the investigations at the scene are complete or as directed by the SIO or, in circumstances where it has not been necessary to appoint an SIO, by the Duty Inspector.

This is in order to preserve evidence should it later become necessary to direct a full forensic examination of the scene.

In the case of suspicious deaths or obvious homicides, a Major Incident/Serious Crime Scene Log, Form 38/15, should be opened and the integrity of the scene preserved.

Ideally the Log Officer should have previous experience of completing a scene log. Service Instruction for Serious Crime

Scenes details the completion of Serious Crime Scene Logs.

Where the body is that of a child or young person under the age of 18, the 'Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland' must be complied with.

Scene Log Officers should consult with the senior officer at the scene in relation to requests from persons wishing to enter the scene e.g. priest wishing to administer last rites. All such requests will be considered individually and if a decision is made to allow entry, full forensic protection will be required.

### **Police Required To Attend The Scene**

In addition to the first officer responding, a Sergeant must attend the scene of every death. The Sergeant should be satisfied as to the proper extent of the police enquiries being made or required to be made into the incident and make an initial assessment as to the nature and cause of death. The investigation should include house-to-house or local enquiries if deemed necessary by the Sergeant given the circumstances of the death and based on the geography of the area. A record must be kept of the enquiries made.

A Reactive Organised Crime (ROC) Detective Sergeant should be tasked immediately to attend the scene where the Sergeant believes that the death is suspicious. In these cases a phone call from the ROC Detective Sergeant is not acceptable; they must physically attend the scene.

A Detective Inspector (DI) should be consulted where the ROC Detective Sergeant believes the death is suspicious. During this consultation, the DI should satisfy themselves that the scene is being managed and that all appropriate lines of enquiry are being followed. The DI should consider attending the scene and where they decide that it is unnecessary to do so, they will record the reason for that decision.

Consideration should be given at this stage to the attendance of a CSI.

On Call Major Investigation Team (MIT) SIO shall be tasked through the callout desk at Urban Contact management Centre (UCMC) if the death is suspicious or a confirmed homicide. The SIO should refer to the Forensic Pathology Practice Advice for Police (Authorised Professional Practice), currently the Murder Investigation Manual.

In the case of a SUDI, i.e. the Unexpected Death of a Child under 2, the Public

Protection Unit (PPU) Inspector should be tasked to the scene. A Child Abuse Investigation Unit (CAIU) Officer should also attend. For further information, [see Chapter 5](#).

A clear record must be kept of who is in charge of the investigation at each stage. These details should be recorded on the NICHE OEL and the Serious Crime Scene Log (38/15) where appropriate.

### **Notifying the Coroner**

The Police will notify the Coroner's Office about the death as soon as possible after an initial assessment has been made and before the post mortem is arranged. A post mortem can only be conducted on the authority of the Coroner.

If it is concluded that the death is not suspicious, the Sergeant will appoint a uniform officer to inform the Coroner, conduct the investigation and to attend any post mortem. An inexperienced officer should not be appointed to conduct such an investigation without a high level of supervision.

The Coroner should be contacted prior to the removal of a body from the scene.

The completed Form 19 and SD1 (in cases of suspected suicide) must be submitted to

Occurrence and Case management Team (OCMT) in the case of all deaths being investigated on behalf of the Coroner. OCMT will then take responsibility for marking any deceased person who currently exists on NICHE as 'Deceased', or if required for a business need, will create the NICHE nominal and again mark them as 'Deceased'.

Officers who encounter the death of a suspect/witness as part of an ongoing investigation or prosecution file should also contact their relevant OCMT (not CRO) and provide sufficient detail to allow the individual to be identified on NICHE and again correctly marked as 'deceased' by OCMT.

In the case of a SUDI, i.e. the Unexpected Death of a Child under 2, Form SUDI 1 must be completed. For further information on this, as well as the completion of National Policing Improvement Agency (NPIA) Form 76, [see Chapter 5](#).

This officer will also prepare an Inquest file if called for by the Coroner. Any actions from the Coroner's Service will be e-mailed to the OCMT in the relevant District and work flowed from there to the IO via NICHE. Officers should make themselves aware of what is expected of them and fully comply with the issued instructions. Supervisors have a responsibility to ensure

that actions are completed in a timely fashion and are reminded of their obligations to manage and quality-assure occurrences and case files on NICHE.

Where the death is considered to be suspicious from the outset, an appropriately experienced Detective from Reactive Organise Crime (ROC) /MIT must attend the post mortem with Crime Scene Investigator (CSI) and/or Photographer, as considered appropriate by the SIO. In the case of a SUDI, i.e. the Unexpected Death of a Child under 2, [see Chapter 5](#).

#### **Assistance from the Pathologist**

The duty pathologist may be contacted for advice concerning any suspicious death under investigation and may agree to attend the scene, where this is necessary. Such requests should be made through the callout desk at UCMC.

A fully briefed officer will speak, by telephone, to the pathologist when requesting their attendance at the scene of a suspicious death.

#### **Photographic/Video Record of The Scene**

Photographs should be taken of the scene under direction of the SIO, IO, or specialists acting on their behalf.

A video and/or R2s spherical images of the scene should be considered following consultation with Scientific Support to facilitate the pathologist in their examination/interpretation as to the cause of death.

#### **Removal of Remains from the Scene**

In cases where a post mortem is likely to be required, the remains must be removed to the NI Regional Forensic Mortuary within the RVH complex by a contracted Coroner's undertaker (unless already done so by ambulance etc.).

The call out desk at UCMC holds details of the contracted undertaker. Under no circumstances should any other undertaker be appointed to remove remains to the mortuary on behalf of the Coroner. Whilst a bereaved family may wish to appoint their own undertaker, police should carefully explain that the removal process (when a post mortem is required) is contracted but that following a post mortem, the family undertaker may take over duties on behalf of the family. Where the Coroner's contracted undertaker is appointed, police should refer to them as such in the presence of the deceased's family and not by their company name.

In cases where no post mortem is required, the family may nominate an undertaker to remove the remains.

At the scene of a suspicious death, CSI personnel will place the remains in a forensic body bag, seal it with a numbered tag and photograph the seal.

The contracted undertaker will then transport the remains to the mortuary accompanied by police. In the case of a fatal RTC, CSI do not always attend, depending on the circumstances. The remains must still be placed in a forensic body bag as this clarifies to mortuary staff that the death is not a routine, non-suspicious death.

In the case of a SUDI, i.e. the Unexpected Death of a Child under 2, Form SD2 must be completed and provided to the parent/carer.

In circumstances where there is no suspicion of a crime having been committed but the body has to go to the mortuary pending a decision re the issue of a death certificate or Form 14 (otherwise known as the pro-forma), police are not required to accompany the body. They must however complete a mortuary admission sheet (Form P4-NI Regional Forensic Mortuary Admission Sheet available on PoliceNet) which accompanies the body to the mortuary. The admission sheet must accompany the body at all times. It should be completed by the initial

IO, and should include details of the relevant ROC officer, where applicable.

Where a death is treated as suspicious, the SIO or, if none appointed, the IO is responsible for ensuring continuity of the body. The Forensic Mortuary must be used in all suspicious deaths and obvious homicides. The SIO/IO must designate an officer to accompany the body from the crime scene to the mortuary, and to identify the body to the pathologist.

Where possible, the initial IO should accompany the body to the mortuary. A mortuary admission sheet, (Form P4-NI Regional Forensic Mortuary Admission Sheet available on PoliceNet) must be completed and conveyed with the body to the mortuary.

Please note that there are 2 mortuaries within the RVH complex. The NI Regional Forensic Mortuary performs both forensic and routine PMs. It is attached to the Belfast Trust Mortuary, which will admit remains from deaths in the RVH (unless suspicious) and SUDI or Deaths of Children under 2 (unless suspicious). The State Pathology Department is situated on the first floor above both of these buildings. There is no mortuary within the main Royal Victoria Hospital (RVH).

In circumstances where the deceased has been suffering from a terminal illness and it is not possible to get a death certificate issued (after hours etc.), the Coroner's Office advises that the remains should be moved by a family undertaker to their premises, or the local hospital mortuary, with the proviso that they are not disturbed (clothing removed/ embalmed etc.) until a death certificate is issued.

The decision to close the scene should only be taken by the SIO or Duty Sergeant after consultation with the Duty Inspector who is fully satisfied that the examination is complete.

Where a post mortem is to be conducted in relation to a suspicious death, the scene should be held until such an examination is complete.

**Safe Custody of Property of the Deceased**

Where it comes to the knowledge of the police that a person has died and the Next of Kin (NOK) or any near relative is unknown or not available, the officer at the scene will ensure the safe custody of all property belonging to the deceased. They will take possession of any money or property such as bank books, insurance policies, deeds and personal items of a valuable nature such as jewellery and will record the details immediately on NICHE

property. Pension books, medical and national insurance cards will be forwarded to the appropriate departments. All monies should be reported to the District Business Manager who will advise on retention/disposal. All efforts should continue to be made to find the deceased's NOK. Ultimately, the Crown Solicitor's Office will assume responsibility for the property of a deceased person which may include properties, cars etc.

**The Next of Kin (NOK) of the Deceased**

The Human Tissue Act 2004 has established the following order of priority of NOK which should be followed:

- Spouse or partner
- Parent or child
- Brother or sister
- Grandparent or Grandchild
- Step parent
- Half-brother/sister
- Longstanding friend.

The IO should inform the CLO of any known family dynamics such as split families and spouses separated but not divorced.

### Attendance at the Post Mortem

A Form 19 (Police Report Concerning Death) should be completed and promptly submitted in all Coroner's cases. A copy of the Form 19 must be emailed to the relevant OCMT office. OCMT must email the details to

Coronersoffice@courtsni.gov.uk. A Form 19 is not required in cases where a Doctor signs a death certificate.

A Form P1 (Details required for Coroner's post-mortem examinations) must be completed where the Coroner has directed a post mortem be conducted.

The Coroner's Office will provide a CLO who will contact the family of the deceased and liaise with them and other agencies in relation to release of remains etc. In homicide cases, the CLO will agree contact with the PSNI FLO. In cases where no FLO is appointed, but the death is being treated as suspicious, police will update the deceased's family on any aspect of the police investigation deemed appropriate by the IO or SIO.

The completed Form SUDI 1 must be brought to the post mortem in the case of a SUDI i.e. the Unexpected Death of a Child under 2. For further information [see Chapter 5](#).

The IO/SIO or suitable officer appointed by the IO/SIO should attend the post mortem.

If an FMO attended the scene, a copy of their report must be obtained and brought to the post mortem.

Every effort should be made to ensure that photographs of the scene are also brought to the post mortem. Where possible, the same CSI and photographer who attended the scene should also attend the post mortem. The IO or nominated deputy should direct the CSI/photographer as to the extent of any samples/photographs to be taken. The pathologist conducting the post mortem will direct the photographer during the examination.

If the death has occurred in the A&E department of a hospital, the pathologist may request that ante-mortem bloods are collected by police from the hospital. These are bloods routinely taken when the patient is still alive and are very beneficial to a pathologist, especially in drug related deaths. If requested by the pathologist, the Coroner's Service will contact the hospital to release the bloods to the police under Coroner's legislation.

It is the responsibility of the police acting as the Coroner's agent to establish identity on behalf of the Coroner. This is usually done visually but sometimes involves the taking of fingerprints, samples for DNA comparison or the use of dental records. The police may ask the pathologist for

guidance on what is appropriate identification in the circumstances.

The police must be facilitated in this important role. Identification must normally take place before the body is prepared for autopsy. If, for any reason this is not possible, the Coroner must be consulted. An identified body must immediately be securely labelled with a wrist and/or ankle band. If labelling has already occurred, its accuracy must be verified by PSNI and mortuary staff.

### **Briefing the Pathologist**

A pathologist is appointed by and acts under the instructions of the Coroner. The IO or SIO's nominated briefing officer should brief the pathologist on the layout of the scene, the circumstances in which the deceased was found, the result of the initial enquiries and any areas of concern. In the case of a SUDI or a child under 2, the information contained within completed Form SUDI 1 should also be shared.

The pathologist should be provided with a completed Form P1 (Details Required for Coroner's Post Mortem Examinations). The IO or SIO's nominated briefing officer should also be in possession of the deceased's medical history to present to the pathologist. All that is required is a clinical summary from the deceased's GP

detailing the deceased's medical condition(s) and prescribed medications. This should normally be no more than two A4 pages. Full medical notes are not required unless specifically requested by the pathologist or the Coroner.

In the case of the death of a recently-settled migrant to N Ireland, check with family members if they have been registered with a GP and, if so, retrieve anything related to them from the GP's surgery. If they have not yet registered with a GP, contact the relevant Embassy for any details they hold. Take further direction from the Coroner if medical notes are genuinely not available. In such instances, the post mortem can go ahead, but you must record efforts you have made to trace records on the OEL and in your notebook.

It is important that the briefing officer is in a position to provide the pathologist with details of particular issues or suspicions that the police officer wishes the post mortem to clarify. Where the pathologist requests copies of statements, maps or video then these must be provided as soon as practicable.

In SUDI cases, any relevant information pertaining to the family environment, the parents' demeanour and accounts leading up to the infant's death, should be brought

to the pathologist's attention prior to the post mortem.

### **Post Mortem Examination Log – Form P3**

A post mortem examination log – Form P3 will only be completed for suspicious deaths.

The post mortem examination and associated recovery of potential evidence types should be conducted and viewed as a crime scene in all suspicious deaths including obvious homicides.

The purpose of the post mortem log Form P3 is to maintain a detailed and contemporaneous written record of the post mortem examination. The Log Officer must include the accurate recording of all actions and preliminary cause of death.

Where the death is treated as suspicious, the SIO or IO will nominate a Log Officer who is not involved in the recovery of evidence types associated with the post mortem examination. The Log Officer will be responsible for completing all sections of the post mortem log and ensuring the guidance notes on the front cover of the log are complied with.

As is the procedure for other crime scene logs, upon completion of the post mortem examination, the Log Officer will, as soon as practicable, give the completed post

mortem log to the IO for information and inclusion in the investigation papers.

The IO will notify the findings of the post mortem directly to their supervisor and the Coroner. If the officer is unsure of medical terms used, an explanation must be requested. The Preliminary Cause of Death Form (C1) must be delivered or faxed to the Coroner's Office before leaving the. A copy of this form must be kept mortuary and included in the Inquest file.

On every occasion following a post mortem the pathologist will complete a Preliminary Cause of Death Form (C1). Where items of human tissue have been seized for a police investigation a Form C1(a) will also be completed by the pathologist. The C1 and, if applicable, the C1(a) must be faxed by the IO to the Coroner's Office before leaving the mortuary. A copy of these forms must be kept and included in the inquest and prosecution file. Additionally, the C1 and C1a must be attached to the reports tab on NICHE.

Any samples taken at the post mortem requiring to be examined at by Forensic Science NI (FSNI) e.g. blood, urine, stomach contents need to be submitted ideally within 48 hours but definitely no later the 10 days after the post mortem. Liaise with your District property manager in relation to barcoding samples, logging

them on NICHE property and transporting them to FSNI.

### **Actions following Post Mortem**

Following a post mortem where the pathologist is of the opinion that the death was due to natural causes and the ROC DI/SIO, having considered all the facts, directs that the death is non-suspicious, future investigation will be conducted by a uniform officer on behalf of the Coroner. This decision and rationale must be recorded on NICHE. However, the investigation will not be returned to a uniform officer until it has been discussed at SIO, ROC DI and Duty Inspector level and agreement is reached that this is appropriate.

Where investigations are conducted by uniform officers, supervisors should give consideration to 'civilianising' the encounter during witness interviews and the statement gathering process to minimise the distress of grieving families.

The Coroner's Office must be informed at the earliest opportunity by telephone that the death will be investigated by police on behalf of the Coroner. In these cases, a comprehensive Current Situation Report (CSR) of the investigation to date together with relevant documents must be completed by the allocated ROC Detective

and handed to the Duty Inspector. The relevant NICHE Log entry and Command and Control entry must be updated by ROC to reflect that this death is no longer considered suspicious and must include the name of the uniform IO. Please note that any human tissue samples taken at the PM remain the responsibility of the attending ROC Officer right through to disposal.

If, in the unusual circumstance that following post mortem a death remains unexplained, decisions on how to proceed will be reached, following discussion between the Duty Inspector and DI. Advice should be sought from the MIT SIO. The decision and rationale will be recorded on NICHE. A death should be treated as suspicious until the contrary is established. Please bear in mind that cause of death is sometimes not determined until toxicology results are received.

If at any time during a post mortem following a death treated as non-suspicious, the pathologist becomes concerned that the death may be suspicious, or new information becomes apparent suggesting the death may be suspicious, the post mortem should be suspended and the ROC DI informed who, if necessary, will contact the on call MIT SIO. The MIT SIO will be responsible for

the deployment of any Scientific Support resources such as Photography and a Major Crime Forensic Advisor (MCFA) prior to the resumption of the post mortem. A new post mortem examination log P3 should be commenced.

Following a post mortem where the DI is of the opinion that the death is suspicious, this should be investigated as a homicide until the contrary is established.

### **Sudden Death Register**

Following post mortem, the relevant details surrounding the cause of death should be included in the District Sudden Death Register which should be updated as the investigation progresses. The Sudden Death Register is normally electronic and maintained by OCMT on the 'G' Drive.

The Coroner's Liaison Member in each OCMT office will be responsible for Inquest file submission and for updating the Sudden Death Register.

### **Results of Tests**

Where the cause of death is dependent on further tests at the pathology or forensic laboratories, then the results must be brought to the immediate attention of the ROC DI/SIO who will direct any subsequent enquiries.

Whilst FSNI generally communicate directly with State Pathologist's Department (SPD), the IO should ensure that the pathologist is aware of these results. This can be done initially by telephone, but must be followed up in writing by letter or email.

### **Notifying the Family of the Preliminary Cause of Death and of the Retention of Human Tissue.**

The Coroner's Office will notify the family of the initial cause of death and inform the NOK of any human tissue retained. In cases where a police FLO is allocated they must liaise with the Coroner's Office to ensure they are fully aware of these details.

The onus is on the SIO/IO to inform the Coroner's Office regarding the release of information where it may impact on an investigation.

### **Receipt of Post Mortem Report**

When the post mortem report is completed the State Pathologist's Department will inform the IO. The IO shall contact the Coroner's Office and request a copy of the post mortem report for inclusion in the investigation papers.

On occasions where a delay occurs on the availability of a post mortem report, the submission of the inquest file should not be delayed but should be submitted

highlighting the delay. When the post mortem report becomes available, the Coroner's Office will send the IO a copy for retention on NICHE and they will insert a copy into the inquest file for the IO.

### **Inquests**

When requested by the Coroner, the OCMT Coroner's Liaison Member will ensure that the investigation has been satisfactorily completed and will forward electronic copies of the statements to the Coroner's Office.

The Coroner will notify the relevant OCMT and Ops Planning office of the Inquest date and necessary witnesses.

Prior to witness invitations being issued, the Coroner will write to the next of kin notifying them of the Inquest date.

Following the inquest, the Coroner will send a copy of the verdict to the OCMT for their retention.

In cases where the cause of death has been established, the Coroner may decide that an inquest is unnecessary.

The IO will be informed by the Coroner's Office. The bottom section of the Form 19 will be returned to OCMT confirming no Inquest. Subsequently, the Coroner will give formal notice to the Registrar of Deaths of the decision. In such cases the

investigation papers, including details of the initial police response, should be retained by the OCMT and subsequently reviewed for retention/disposal in compliance with current records management policy.

### **Deaths Occurring under Specific Circumstances**

#### **Deaths in Prison**

Due to the unique environment of prisons, there is a raised potential for foul play and, as such, deaths in prison are likely to be contentious, intensely scrutinised and will always be independently reported on by the Prisoner Ombudsman.

All deaths in prison or PSNI custody must be considered suspicious in the first instance. As such, a ROC Detective Sergeant will attend the scene of every death in prison and investigate as suspicious until the contrary is established. The Prison Service has arrangements to notify local police who act on behalf of the Coroner.

The State Pathologist's Department must always be consulted and given the opportunity to attend the scene.

A photographer should attend the post mortem.

### **Death in Police Custody or Death following Contact with Police**

See the Service Instruction on the Role of the Police Ombudsman.

### **Death in the Workplace**

The following link may assist in investigating work-related deaths:

**MoU for Investigation of Work-Related Deaths - Northern Ireland Agreement (HSENI/ OPONI/PSNI/CEHOG)** (Click here)

If the incident is a work related death on police premises the IO must also notify the PSNI Health and Safety Branch, Lisnasharragh. (Out of hours contact can be made through UCMC).

Health and Safety Branch will notify and liaise with the Health and Safety Executive Northern Ireland (HSENI), government enforcing agency for Health and Safety.

### **Suicide**

As with any death, a suspected suicide is upsetting for families and friends. Officers should at all times conduct themselves in a professional manner, bearing in mind the sensitivity of the situation.

The primary duty of police is to preserve life, therefore officers responding to a report of suicide should physically check for signs of life without making assumption.

When an FMO or GP arrives at the scene of a death and, after consultation with the IO, decide that the death is likely to be a probable or possible suicide, the following steps should be taken:

- A Form SD1 should be completed in conjunction with the Form 19. The purpose of this form is to highlight the incident to the local HSC Trust and the Public Health Agency (PHA) to enable them to implement support measures for family or friends. The details are also used to identify trends or local community issues that may lead to the identification of other vulnerable persons in the community who may be affected by the incident and/or where there is evidence of a suspected cluster, to initiate a Community Response Plan to help prevent further potential suicides or incidents of self-harming. It is therefore imperative that the permission of the family is sought for a referral to the HSC Trust to provide them with support and assistance;
- The IO will e-mail the completed Form SD1 to the relevant OCMT by the completion of their turn of duty. Supervisors must ensure

compliance with this instruction. In the event that there is a valid reason that an IO cannot submit a completed form SD1 within the timescale specified, supervisors must ensure that there is some contingency to have this form submitted within 24 hours;

- The Coroner's Liaison Member within OCMT, on receiving Form SD1, will forward it to the identified individuals in the local Health Trust and the PHA within 24 hours of receipt;
- Where it is suspected that a child i.e. someone under the age of 18 has taken their own life, the matter must be reported as soon as practicable to the relevant HSC Trust where the child normally resides and the relevant PPU Inspector for 'Case Management Review' consideration.

### **Attending the Scene of a Suspected Hanging**

A hanging, as with any death, should be treated with caution to ensure it is not a murder. All forms of evidence to suggest it is a suicide have to be assessed and recorded. All hangings and the surrounding scene should be evidentially photographed

as a minimum standard. All chairs, ladders, boxes etc. used by the person should be left in situ. The rope, cable, chain, hose, tie etc. should be left in situ to be assessed and recorded by the CSI and ultimately by the pathologist. The ligature must not be untied. If the police officer or health worker at the scene believes the person may still be alive and the rope has to be cut to enable life-saving actions then it must be cut away from the ligature - it should not be untied.

Any ligature used should be retained for the post mortem and subsequent inquest if applicable.

### **Deaths in Hospital**

A hospital death reported to police should be treated in the same way as a death in the community. A Sergeant should attend the scene as they would with any death reported to police.

Where death occurs in a hospital, the body should be taken to the hospital mortuary while the Coroner decides how to further the investigation. When police are informed of the death by the Coroner and a PM is to take place, they will attend the hospital to retrieve a clinical summary and any necessary additional information or statements. The medical notes of the deceased may be obtained at a later time in accordance with Trust procedures.

Officers should ensure that no notes are given to them by the ward staff unless specifically requested by the pathologist. If a death in hospital is deemed suspicious, the Coroner's contracted undertaker should be contacted by police to remove the remains from the hospital to the NI Regional Forensic Mortuary for post mortem.

The post mortem may take place in the hospital mortuary or, if directed by the Coroner, in the NI Regional Forensic Mortuary (NIRFM) at the RVH complex. All removals on behalf of the Coroner from a hospital mortuary to NIRFM must be performed by the Coroner's contracted undertaker. (NB: NIRFM staff will transfer bodies from the Belfast Trust Mortuary to NIRFM.) . All deaths in A&E, where a post mortem has been directed by the Coroner, will go to NIRFM for the post mortem, regardless of whether they are deemed suspicious or not.

If the death is being treated as suspicious, the remains must be removed from the hospital ward or the hospital mortuary by the Coroner's contracted undertaker. All steps outlined in this instruction in relation to investigating suspicious deaths must be followed.

In the case of the death of a child under 2 years, whether at home or in hospital, the post mortem will take place in the Belfast Trust Mortuary, unless it is deemed suspicious. As with all suspicious deaths, the remains will go to NIRFM.

In all cases of deaths in hospital, police should liaise closely with the hospital and mortuary staff, adhere to local Trust protocols and follow the directions of the Coroner in respect of any movement of the remains.

### 3. Identification of Deceased Persons

#### Identification

Identification of the deceased is a critical step in the investigative process, and a key function of the Police on behalf of the Coroner. Whilst misidentification of an individual substantially impacts on public confidence in Policing, the impact on the bereaved can often be irreversible.

Visual identification is the most common form of process which is used by Police when undertaking death investigations.

Usually an individual who knows the deceased well will view them and confirm to the investigating officer their identity. When this process is used it is essential that the officer receiving the details is satisfied beyond reasonable doubt that the identification has been properly made.

To achieve this, an officer to whom the identification is made should be completely satisfied that:

- (i) The person making the identification is in a fit condition to do so;
- (ii) The person identifying the deceased knows the individual appropriately to do so; and
- (iii) The condition of the deceased makes visual identification possible.

When reporting the facts to the Pathologist, Investigating Officers should be in a position to confirm the identity of the deceased, and also provide the evidence which corroborates the identity.

If the investigating officer is not satisfied that one person has identified the deceased beyond reasonable doubt it is acceptable to seek additional confirmation through further visual identification. This should normally be undertaken by a person 'one step removed' from the deceased. Once the officer is satisfied beyond reasonable doubt the facts can be presented to the Pathologist.

In some cases visual identification is not possible either as a result of:

- (i) The condition of the deceased as a result of decomposition, disruption or burning; or
- (ii) It is not possible to find anyone to visually identify the deceased beyond reasonable doubt.

In these circumstances 'primary identifiers' must be considered. Primary identifiers are:

- (i) Odontology (dentistry);
- (ii) Ridgeology (fingerprints); or
- (iii) DNA.

In most cases the Pathologist will recommend the primary identifier which should be used.

In cases involving foreign nationals an international system of data collection and recording is used in accordance with Interpol guidance. The Body Recovery and Identification Team can provide advice and guidance in relation to this process to Investigating Officers if required.

**Disaster Victim Identification (body recovery and identification)**

Emergencies or Major Incidents may result in mass fatalities. The processes and procedures for death investigations (including recovery and identification of the deceased and the support given to family and friends throughout the process) is known as Disaster Victim Identification (DVI). The DVI process is delivered according to [Authorised Professional Practice](#) provided by the College of Policing.

The PSNI maintains a cadre of staff trained in body recovery and identification, casualty bureau and family liaison to support any mass fatality incident in line with national and international guidance.

In addition to the DVI role the Body Recovery and Identification Team can be called upon in circumstances in which:

- (i) Multiple fatalities have occurred and identification may become an issue;
- (ii) The deceased is significantly disrupted (in order to ensure the remains are fully and appropriately recovered);
- (iii) The deceased is at a stage of decomposition where recovery will be complex;
- (iv) The deceased is significantly burnt;
- (v) The manner of the death makes recovery complex or requires specialist technical skills (such as entrapment in machinery);
- (vi) The manner of the death presents chemical, biological or radiological hazards to the public, responders or healthcare professionals (such as hospital or mortuary staff); or
- (vii) Identification of the deceased is or may be at issue.

In any of the circumstances outlined above the Investigating Officer should contact the on call Body Recovery and Identification Officer for advice and / or deployment. Additional details are held by the callout desk at PVI.

Body Recovery and Identification Officers deploy in support of the Investigating Officer and can assist at any stage of the death investigation process if required.

**Chemical suicide (individual chemical exposure events)**

Chemical suicides (officially known as individual chemical exposure (ICE) events) are characterised by the use of a chemical or mixture of chemicals with the intent to self-harm, usually as a result of ingestion or inhalation.

Deaths in these circumstances can present a serious risk to the public, to the emergency services and to other health workers (such as hospital and mortuary staff) who may come into contact with the deceased or the contaminant.

Officers responding to suicides which they believe may be linked to chemical exposure should follow the CBRNe Initial Operational Response Guidance contained in Chemical, Biological, Radiological or Nuclear incidents (CBRNe/HazMat) Service Instruction. Scene management and investigation of such sudden deaths is delivered in partnership with Specialist Fire and Ambulance colleagues in line with the Joint Emergency Services Interoperability Principles (JESIP).

**Deaths involving chemical, biological or radiological contamination**

Occasionally (directly or indirectly) the cause of death may involve contamination of the deceased. Deaths in these circumstances can present a serious risk to

the public, to the emergency services and to other health workers (such as hospital and mortuary staff) who may come into contact with the deceased or the contaminant.

The hazards may arise directly from external contaminant, or indirectly from material which can be released during the post mortem process.

Officers responding to deaths which they believe may involve contamination should follow the CBRNe Initial Operational Response Guidance contained in Chemical, Biological, Radiological or Nuclear incidents (CBRNe/HazMat) Service Instruction. Scene management and investigation of such sudden deaths is delivered in partnership with Specialist Fire and Ambulance colleagues in line with the Joint Emergency Services Interoperability Principles (JESIP).

## 4. Stillbirth

### Background

In 2013 the Court of Appeal in Northern Ireland upheld an appeal by the Attorney General for Northern Ireland that the Coroner should conduct an Inquest into a stillbirth. The judgement concluded that, in relation to the Coroner's Act (Northern Ireland) 1959, the definition of a deceased person includes 'a foetus in utero then capable of being born alive'.

This judgement had clear implications for reporting stillbirths to the Coroner and the point at which the foetus ceases to be capable of life is crucial to that report. Currently, the legal age limit for the viability of a foetus is 24 + 0 weeks gestation period. If the demise of a foetus occurs early in pregnancy at a point where independent life is not possible, then it will not be a foetus 'capable of being born alive' and therefore should not be reported to the Coroner.

Equally, if the demise of a foetus in utero (i.e. in the womb) occurs as a result of some defect which would mean it could not survive birth, then again it is not capable of being born alive and should not be reported to the Coroner. If the infant survives the process of labour but subsequently dies and the death is due to natural causes and

is anticipated, then the neo-natal death should not be reported to the Coroner.

### Introduction

Where a stillbirth is deemed to be a reportable case, it will be reported to the Coroner by a senior clinician.

The Coroner will then decide whether the stillbirth will require a Coroner's post mortem to determine the cause of death or alternatively direct the reporting clinician to issue a stillbirth Certificate or Pro Forma.

If a Coroner's post mortem is required, the Coroner's Office will report the case to the Belfast Trust Mortuary and the PSNI. The PSNI will investigate the stillbirth on behalf of the Coroner and present their findings to the paediatric pathologist prior to the post mortem as per normal procedures.

In cases of intra-partum death/stillbirth (i.e. death during labour), there is likely to be a significant coronial investigation but initial police actions will be similar regardless of whether the intrauterine death occurred prior to or during labour.

The role of the PSNI, as agents of the Coroner, is to investigate stillbirths which are non-suspicious or attended by suspicious circumstances. Where doubts arise as to the cause of the demise of the foetus during an investigation, the IO

should report the circumstances to the Coroner without delay.

Officers should note that in the vast majority of cases, death of the foetus will have occurred naturally through placental disease or foetal abnormalities. To mitigate the trauma for bereaved parents, the need for sensitive and effective communication, cooperation and collaboration between police, clinicians and pathologist is essential in stillbirth cases.

### **Police Engagement with the Parents following a Stillbirth**

In the vast majority of reportable stillbirth cases, there will be no requirement for direct police contact with the bereaved parents.

Where such contact is necessary, sensitive engagement with the bereaved parents following the birth is crucial to allow the parents to understand why their baby's case is being reported to the Coroner and to ensure engagement does not negatively influence their grief. In some cases, the parents will have long term clinical and psychological needs and the behaviours of attending professionals, including police, is of great importance.

Investigating officers should also be mindful that the parents will be in the initial stages of coming to terms with their loss

and, as such, may appear traumatised, shocked, numb, withdrawn, or extremely emotional. These natural reactions to bereavement will be greatly exacerbated should the parents perceive that they are being treated as 'suspects', a perception which can further be compounded by the fact that mothers bereaved by stillbirth may experience emotions linked to guilt associated with the demise of their baby.

Notwithstanding investigative necessity, police attendance at a hospital or other location to engage with bereaved parents should normally be kept to a minimum.

To minimise further distress to bereaved parents, initial hospital or home visits and all subsequent meetings or interviews with the parents should be civilianised where possible i.e. conducted in plain clothes using unmarked vehicles.

Given the unique sensitivities around stillborn cases, it is imperative that IOs are fully aware of the role of the PSNI and the purpose of the post mortem if engaged in conversations with grieving parents or relatives.

The challenge for PSNI officers involved in the investigation will be to find a balance between investigative professionalism and empathetic engagement with the bereaved parents.

### Initial Police Response

Most stillbirths will occur in a hospital and the clinical team will normally be aware of the demise of the foetus prior to labour and stillbirth occurring. Many stillbirths, however, occur in the community and are only confirmed in hospital.

In a small number of cases, a stillbirth may occur unexpectedly at a home-birth or in a midwife-led unit. Where obstetric treatment is required, the mother and stillborn baby would normally be transferred to the nearest Obstetric Unit for medical assessment. This is the point where the attending clinician will discuss the stillbirth with the Coroner and therefore it is in the setting of an Obstetric Unit (or otherwise the hospital), rather than at home or elsewhere, that police involvement is likely to commence in such cases.

On attendance at the hospital, police should liaise with the Head of Midwifery and attending clinician prior to any contact with the parents.

The IO will make initial enquiries with the clinician and other relevant parties (e.g. the attending midwife) to ascertain the facts and circumstances surrounding the stillbirth.

Officers should record history and background information in as much detail as possible and obtain a copy of the

mother's Maternity Record from the hospital through established protocols. If written statements are required from hospital staff, these will be facilitated through the normal Trust procedure.

The importance of these enquiries cannot be understated since the gathering of comprehensive material facts surrounding the stillbirth from the relevant professionals will reduce the need for any unnecessary and potentially insensitive questions to parents or relatives.

When conducting enquiries with medical and midwifery staff, officers should also be mindful that those professionals in attendance at the stillbirth may also be experiencing adverse emotional reactions to the event.

IOs should ensure that records on police systems are checked for both parents. In addition, the IO should contact the PSNI Domestic Abuse Officer and the relevant Social Services Gateway Team to check for any other relevant information. Police should never disclose to the bereaved family that these checks are being carried out.

In the vast majority of non-suspicious stillborn cases, there will be no requirement for the PSNI to take any statements from

the parents unless specifically authorised or directed by the Coroner.

Where such authorisation or direction is given and following initial discussions with the clinicians, IOs will liaise with their supervisor to agree decisions about how, when and where the parents are to be interviewed and whether they will be interviewed separately or together. All decisions, along with the accompanying rationale, should be clearly recorded in official notebooks or journals.

Where suspicious circumstances surrounding the stillbirth are noted (e.g. a suspicion of 'child destruction'; a suspicion that domestic violence is linked to the stillbirth; or a suspicion of concealed pregnancy), the ROC DI should be tasked immediately. In all other cases, the Duty DI ROC should be contacted immediately.

The ROC DI will appoint a Detective Sergeant to take charge of the investigation in all cases where a stillbirth is attended by suspicious circumstances and the advice of a MIT SIO or the Child Abuse Investigation Unit (CAIU) may be sought. The investigation will then be reviewed regularly by the relevant DI.

The involvement of CSI or Photography personnel in the investigation will be at the discretion of the IO.

### **Hospital Procedures following a Stillbirth**

Hospital delivery suites have regional guidance on evidence-based, holistic care of parents after the experience of miscarriage, stillbirth or neo-natal death which includes such issues as ensuring that the parents have been given the baby's name band and cot cards and that hand and footprints etc. have been taken.

To assist the mother in the grieving process, most delivery suites are equipped with refrigerated cots to allow the mother to remain with her baby until the day of the post mortem examination.

An important aspect of the post mortem examination is ensuring that the placenta is available. It is deemed to be part of the baby and must accompany the remains to the mortuary. In most cases, the placenta will be refrigerated at the hospital to prevent deterioration prior to transportation to the examination along with the baby. It must not be placed in formaldehyde.

It will be the responsibility of the IO, in collaboration with the attending clinician or Head of Midwifery, the CLO and contracted Coroner's undertakers, to arrange removal of the remains (including the placenta) to Belfast Trust Mortuary for post mortem examination.

Only in exceptional cases of investigative necessity (e.g. to preserve evidence) will IOs seek to remove the remains from the mother or otherwise interfere with the delivery suite guidelines on the management of stillbirths. Where such removal is deemed necessary, the IO should consult with their supervisor, the CLO and the attending clinician prior to taking action.

Should other items be removed, which the parents may associate with their baby (e.g. a blanket), officers should strive to ensure that such items are returned (where applicable) in a sensitive and dignified manner.

### **The Admission of Stillbirth Cases for Post Mortem**

A full post mortem examination can usually be undertaken from 12 weeks gestation size.

The Regional Paediatric Pathology Service based at the Belfast Trust Mortuary provides a paediatric post mortem service to Northern Ireland (NB. there is no requirement for a forensic post mortem in stillbirth cases).

Following the Coroner's request for post mortem, the designated PSNI Officer must contact the mortuary to confirm their responsibility for the case.

Police officers should consider whether cultural or religious traditions of the bereaved family can be facilitated prior to a post mortem. If this is not possible due to the need to preserve evidence, this should be sensitively explained to the family.

It is imperative that the CLO arranging a post mortem and the designated police officer provide the following information to the Regional Paediatric Service at the Belfast Trust Mortuary:

- Patient (mother/baby) name;
- Gestational age of the baby;
- Name of the attending clinician;
- Location of the baby;
- Estimated time of arrival of the remains at the Belfast Trust Mortuary;

All remains must be transferred by the Coroner's contacted undertaker for that area in a suitable corrugated plastic box, casket or coffin. If no suitable casket or box is available at the hospital, advice should be sought from the Regional Paediatric Service or Belfast Trust Mortuary.

The container and the remains must both be clearly labelled with the name and date of birth.

Any personal items accompanying the remains should be carefully placed into the container or forwarded separately with the remains. All items should be documented on the accompanying body transfer form. If there is maceration (softening of tissue) or hydrops (excess of water or watery fluid), any accompanying items should be wrapped separately or bagged in order that they do not become stained by fluid or discharges from the body.

On grounds of sensitivity, it may not be advisable to send the baby clothed to the post mortem if there is maceration or hydrops as this may stain the clothing provided by the parents.

In circumstances where there is no suspicion of a crime being committed, police are not required to accompany the remains from the hospital to the mortuary. In all cases, a mortuary admission sheet (or body transfer form) should be completed by the IO and accompany the remains.

Prior to the post mortem, the police should ask the pathologist (via mortuary staff) for guidance on what constitutes appropriate identification of the remains in each case of stillbirth.

On attendance at the post mortem, the IO should provide the paediatric pathologist

with completed PSNI Form P1. The IO should also brief the pathologist on the result of initial enquiries and any areas of concern and be in possession of the mother's Maternity Record and a clinical summary from the relevant clinician. The IO should ensure arrangements are in place for the safe return of the Maternity Record to the relevant hospital.

### **Police Action following Post Mortem**

Where no crime is suspected at the conclusion of the post mortem, the CLO will contact the parents and other agencies in relation to the release of the remains. The Coroner's Office will notify the parents of the preliminary cause of death and, where applicable, the retention of human tissue.

Further investigation following post mortem examination where the circumstances surrounding a stillbirth remain suspicious will progress as per the relevant procedures and guidance contained in [Chapter 2](#) of this instruction. It is important to note that many stillbirths remain unexplained even following a post mortem. Supervisors should consider Occupational Health and Welfare referrals for officers involved in investigating stillbirths on behalf of the Coroner as such investigations are emotive and can be upsetting for officers.

## 5. The Investigation of Sudden Unexpected Deaths in Infants and Children under 2

### Introduction

Despite the huge reduction in infant deaths seen in recent years, some children will still die before they reach the age of one. The majority of these deaths occur as a result of natural causes. A small proportion of deaths are, however, caused deliberately by violence, by maliciously administered substances, or by the careless use of drugs.

Investigating Officers must be aware that as the number of genuine unexplained deaths decreases, so the proportion of all infant deaths, which could be attributed to homicide, is likely to increase; education campaigns will not stop people killing children.

Every child who dies deserves the right to have their sudden and unexplained death fully investigated so that homicide can be excluded and a cause of death identified. One of the implications of Article 2 of the Human Rights Act 1998 is that public authorities have a responsibility to investigate the cause of a suspicious or unlawful death. This will help to support the grieving parents and relatives of the child. It will also enable medical services to

understand the cause of death and, if necessary, to formulate interventions to prevent future child deaths. The police have a key role in the investigation of infant and child deaths and their prime responsibility is to the child as well as to siblings and any future children who may be born into the family concerned.

Sometimes a child is found unexpectedly ill at home and dies soon afterwards in hospital. Such cases should be investigated using these guidelines.

A determined cause of death cannot always be established. Pathologists or Coroners tend to classify such cases as 'sudden unexpected death in infancy' or 'undetermined'. This means that the cause of death has not been established. Coroners also use a narrative verdict to supplement this. Thus, a thorough investigation is required.

### Legal Basis

The legal obligations which underpin how the police investigate the Sudden Unexplained Death of an Infant are contained within the UNCRC, the Human Rights Act 1998 and the European Convention on Human Rights (ECHR) to protect life and to protect individuals from inhuman and degrading treatment.

## **Who should attend a Sudden Infant Death?**

This is a very difficult time for everyone.

The time spent with the family may be brief but our actions greatly influence how the family deal with the bereavement for a long time afterwards. A sympathetic and supportive attitude, whilst maintaining professionalism towards the investigation, is essential. Remember that people are in the first stages of grief. They may be shocked, numb, withdrawn or hysterical.

If the police are the first professionals to attend the scene then urgent medical assistance should be requested as the first priority that is if the child is still there and not already removed to hospital. If an ambulance is not already in attendance then one must be immediately requested unless it is clear that the child has been dead for some time. If this is the case, then an FMO will need to be called to verify death.

Police attendance should be kept to the minimum. Several police officers arriving at the house can be distressing for the family of the deceased, especially if they are uniform officers in marked police cars.

The Public Protection Unit (PPU) Inspector should be tasked to the scene immediately. This Inspector will take charge of the

investigation in all cases of sudden unexpected infant deaths. This applies if the deceased child is still at the scene or if the child's body has been removed to hospital. A CAIU Officer should also be tasked to attend. However, if any obvious suspicious circumstances are subsequently noted, MIT should be advised accordingly.

Service Form SUDI 1, found on Police Net, must be completed in all cases of a Sudden Unexpected Death in Infancy, including suspected homicide. This must be made available to the relevant pathologist as required.

Other forms requiring completion are the National Crime Agency forms that relate to the national database on intrafamilial child homicides or suspicious deaths. These forms should be completed and returned to [childdeathinfo@nca.pnn.Police.uk](mailto:childdeathinfo@nca.pnn.Police.uk).

Officers must record the history and background information given by parents, guardians or carers in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded verbatim. Taking the history from the carers of the deceased is also a good opportunity for the police investigators to assess the carer's account as well as their demeanour and attitude at the time of death.

Effective co-operation and liaison between police, paediatricians and pathologists is very important. The detection of child abuse is part of the standard training of paediatricians, equipping them to carry out an external examination and to arrange the relevant investigations such as a skeletal survey and tests for abnormal bruising. In some areas paediatricians are willing to attend the scene and help the IO establish the likely cause of death.

The Kennedy Report highlights best practice as carrying out joint police and SUDI paediatrician home visits. Early examination of the body, collating relevant information from medical records, gathering information for pathologist(s) and convening a meeting along with all medical professionals involved with the family will assist the investigation.

In SUDI cases the Coroner's Office must be notified as soon as possible.

The senior detective attending will be responsible for deciding whether to request the attendance of a CSI. If items are to be removed or photographs or a video are to be taken, their attendance will be essential.

Where a crime is suspected the matter should be referred to a Major Investigation Team and a FLO deployed to assist the IO.

### **Factors that may increase suspicion**

Some of these factors may be present when death occurs naturally. Conversely, the absence of these factors does not mean the death was due to natural causes. The purpose of this list is to act as a guide for investigators but it should not prevent a thorough analysis of all the circumstances surrounding the death.

Possible factors which may increase suspicion:

- There have been previous unusual illness episodes or recent admissions to hospital;
- There is crusted blood on the face of the type associated with smothering and physical abuse rather than the 'pinkish' mucus associated with resuscitation;
- There are unusual bruises or marks;
- There are foreign bodies in the upper airway;
- The child is older than twelve months;
- The parents or carers have given an inconsistent account of the events surrounding the child's death;
- The child has come from a family in which a previous child has died unexpectedly; however, it is still quite possible for second deaths to occur naturally;

- The child has come from a family or household with a history of drug abuse, alcohol abuse or domestic abuse;
- The child (or sibling) is, or has previously been, on the Child Protection Register;
- Inappropriate delay in seeking help;
- Neglect issues, i.e. observations about the condition of the accommodation, general hygiene and cleanliness, the availability of food, adequacy of clothing and bedding and temperature of the environment in which the child is found are important. This will assist in determining whether there may be any underlying neglect issues involved;

**Factors Common in most Infant Deaths**

Factors common in most infant deaths include:

- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood-stained – this does not mean that the death was unnatural;
- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. There can be slight regurgitation immediately after death;

- Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale;
- Covering of the child’s head by the bedclothes. This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating;
- Wet clothing or bedding (this is usually caused by excessive sweating or micturation before death);
- If the child looked as though they have been roughly handled, remember that this may be the result of attempts at resuscitation.

**Initial Actions by Senior Detective in Attendance**

First, make a visual check of the child and its surroundings, noting any factors as described above. It must be established whether the body has been moved and the current position of the child should be recorded. All other relevant matters should also be recorded.

Explain the investigation to the parents, the role of the police and the purpose of a post-mortem (this may determine the cause of

death or help in giving reasons for death) and ensure that grieving relatives are provided with Service Form SD2 'Sudden and Unexpected Death in Infancy: The Role of Police and What Happens Afterwards'.

As soon as possible, ensure a full history is taken from the carers. Decisions about how the parents are interviewed need to be recorded in the SIO policy file.

Consideration should be given to interviewing the carers separately to avoid the possibility of each contaminating the other's version of events.

Someone who has knowingly killed a child is likely to lie to cover up their actions so any conflicting accounts should raise suspicion. It must be remembered, however, that any bereaved person is likely to be in a state of shock and possibly confused. Repeated questioning of the parent or carer by different police officers should be avoided at this stage if at all possible. Officers should, however, always consider the behavioural response of the parents and take particular note of inappropriate or unusual responses to child death, e.g. remoteness, insensitivity to circumstances, indifference to the death, and disposal of articles.

Ensure that the following is done in all cases:

- Check police systems for all family members;
- Contact the Domestic Abuse Officer and the Child Abuse Investigation Unit (CAIU) to check any additional records they might hold. SIOs should consider involving CAIU Officers on any investigation where the death of a child is suspicious;
- Liaise with the relevant Social Services Gateway Team or 'Out of Hours' Co-ordinator' to ensure their records are checked, including the child protection register (and previous registrations if possible), and involve them in a strategy discussion if appropriate;
- Obtain all details of family members, such as siblings and any foster children, including any history of illness and other relevant information;
- It is good practice to see other children in the family, both as potential sources of information and as an indicator of standards of care given by the parents. It is also important to check on the welfare of siblings and whether any child protection procedures need to take place in relation to them. If so, liaise with the relevant CAIU.

The preservation of the scene and the level of investigation will be relevant and

appropriate to presenting factors.

Consideration should be given to:

- Commencing a scene log;
- Preserving the scene (including recording the room temperature);
- Arranging for photographs and video of the scene and other rooms (this is highly recommended). Note: aerial photography, e.g. of a cot, may also prove beneficial;
- Seizing items such as the child's used bottles, cups, food and medication which may have been administered;
- Seizing bedding and clothing, but only if there are signs of forensic value such as blood, vomit or other residues. (The child's nappy and clothing should remain on the child, but arrangements should be made for them to be seized at the hospital.)

This is not an exhaustive list of actions; it should be treated as a guide only. These actions will not be necessary in every case.

### **Further and Subsequent Action by Police**

If it is considered necessary to remove items from the house, do so with consideration for the parents. Explain that it may help to find out the cause of their

child's death. Before returning the items, the parents must be asked if they actually want them back.

If articles have been kept for a period of time, try to ensure they are presentable and that any official labels or wrappings are removed before returning them. Return any items as soon as possible after the Coroner's verdict or the conclusion of the investigation. The term investigation will include any possible trial or appeal process.

Consideration must be given to evidencing any factors of neglect which may be apparent, such as the temperature of the scene, condition of accommodation, general hygiene and the availability of food and drink.

Details of death must be notified to the Coroner. It may be appropriate for an officer who has already built a rapport with the parent or carer to obtain details on the appropriate form.

Often the first notification to the police occurs when the child is already at the hospital. In such cases consideration should be given to designating scenes, both at the hospital and at the location where the child was first discovered to be unwell.

Medical staff usually interview parents before the police arrive at the hospital in an effort to establish the circumstances surrounding the child's collapse. This account should be sought by investigators as it may prove useful should a different version be provided later.

If the police are aware of the case before the child has been taken to a hospital, then the child's body must be accompanied to the hospital for the purpose of continuity of identification. It is recommended that the body should be taken to a hospital casualty department rather than to a mortuary. This enables a chance of resuscitation and makes it easier to get an early expert physical examination by a paediatrician.

The physical examination should be carried out appropriately and sensitively. The body will normally be transported by ambulance, but it may be appropriate to use the services of an undertaker.

A physical external examination recorded by way of photographs should be undertaken by medical staff and police at the earliest possible stage in order to record any suspicious or unidentifiable marks.

It is entirely natural for a parent or carer to want to hold or touch the dead child. Providing this is done with a professional

(such as a police officer, nurse or social worker) present, it should be allowed in most cases as it is highly unlikely that forensic evidence will be lost. If, however, the death has by this time been considered suspicious, the SIO should, where possible, be consulted before a parent or carer is allowed to hold the child.

If the parents or carers wish to accompany their child to the mortuary, this should normally be accommodated provided they are accompanied by, for example, the police FLO or CAIU officer as appropriate.

Hospital staff often wish to supply bereaved parents with a lock of hair or foot or handprints. Police should only refuse this if there is good reason to believe it would jeopardize the investigation; it is highly unlikely that this would be the case.

If there is any lack of agreement between medical staff and the police about the handling of the body then the Coroner's Office must be informed at once so that the Coroner can decide on the appropriate course of action.

A full skeletal survey should be requested and this should be carried out and interpreted by a paediatric radiologist, or radiologist with paediatric expertise, to ensure the best possible result. It is important that the skeletal survey includes

the whole body. The IO must give a full briefing to the pathologist. This includes showing them the video and photographs of the scene and sharing all of the information gathered thus far.

Whether or not the post-mortem reveals physical signs of injury, it is important that extensive toxicological tests are carried out.

In any case where the death is suspicious, a forensic post-mortem must take place. If a pathologist does not have paediatric experience, good practice dictates they work alongside a paediatric pathologist or pathologist with paediatric experience to maximize the opportunity for the recovery and interpretation of evidence.

It is good practice for the SIO to call upon the Specialist Operations Centre at the National Policing Improvement Agency who can provide an up-to-date list of experts as well as knowledge of the latest investigative techniques.

### **Non-accidental Head Injuries**

Some children die, or are seriously injured, as a result of non-accidental head injury. Unfortunately such incidences are not rare, but from an investigative point of view, it is relatively easy to ascertain that the death

should be considered suspicious. Expert paediatric assessment may quickly reveal the presence of retinal and subdural haemorrhages, bruising or other head injuries.

It takes an immense amount of force to cause head injuries severe enough to kill a child, and although feelings of sympathy for the parents or carers may well manifest themselves, it is essential that a detailed and professional homicide investigation is commenced as soon as police become aware of the case. An SIO should, therefore, take control from the outset and the guidance contained in ACPO (2006) Murder Investigation Manual should be applied in the same way as if the victim was an adult.

These are, invariably, difficult investigations that need to involve highly specialised techniques for evidence gathering in addition to the advice previously given in respect of all infant deaths.

As a guide, some of the specialised techniques which should be employed include:

- Full skeletal survey, from head to finger and toe tips interpreted by two paediatric radiologists;
- Ultraviolet photography;

- Ophthalmological examination including specialised retinal photography;
- If the child is on life support, MRI and CT scans, ensuring that the machine is set up for brain matter;
- Full post-mortem ophthalmological examination, carried out in a specialised laboratory;
- Full post-mortem examination of the brain, carried out in a specialised laboratory;
- The services of a forensic analyst to provide a detailed timeline of all significant events in the child's life.

**Note:** This is not an exhaustive list. As techniques change and improve regularly, advice should be sought from experts in every case.

A great deal of the evidence used in any prosecution will be from medical and scientific experts. SIOs must, however, guard against assuming that paediatricians and other medical personnel will automatically carry out the appropriate tests.

Their expertise is in healing sick children, not in gathering evidence for a homicide investigation. Investigating police officers must maintain a clear dialogue with

medical professionals and ensure each party understands exactly what is needed and why it is needed.

### **Additional Information**

Where there is serious disagreement between prosecution and defence experts, the prosecution should not be continued unless there is other evidence. In his judgement in *R v Angela Cannings* [2004] EWCA Crim 01 Lord Justice Judge stated:

*“In cases like the present, if the outcome of the trial depends exclusively, almost exclusively on a serious disagreement between distinguished and reputable experts, it will often be unwise, and therefore unsafe, to proceed.”*

Pre-trial meetings between experts were subsequently recommended in Baroness Kennedy's 2004 report into Sudden Unexplained Death in Infancy where she says:

*“It is our recommendation that in cases that essentially turn on expert testimony, the Judge should order that the experts meet and clarify areas of conflict and report back to the Court. This will help to clarify the issues of content and enable the court to evaluate whether the case should be proceeding.”*

Following the Court of Appeal judgement in R v Cannings 2003, if there are two views and both are equally valid, it would be unwise to proceed with a trial against an accused, as the outcome may well be unjust.

**Coroner/Pathologist**

Early notification and full discussion with the Coroner is essential. The Coroner will give directions to the pathologists and police concerning the post- mortem and the following considerations:

- A joint PM – forensic, paediatric and/or neuro pathologist;
- A biochemical investigation on the direction of the pathologist to include swabs, blood, urine, bile and gastric aspirate for toxicology, Acyl Carnitine profile, amino acids, organic acids and cultures;

The pathologist is duty bound to act on instructions from the Coroner.

**Multi-Agency Referral**

It should always be remembered that SUDI, as with any other form of child protection referral, should be dealt with in accordance with the 'Protocol for Joint Investigation'.

## 6. The Investigation of Suspected Drug Related Deaths

### Introduction

Drug abuse and its consequences are everyday problems encountered globally, and Northern Ireland is no exception. The PSNI will endeavour to ensure that the level of service provided into the prevention of drug related deaths is commensurate with the high level of public interest.

The purpose of this chapter is to outline PSNI's response to those deaths which appear to be, or are subsequently identified as being potentially related to illicit drugs<sup>1</sup> or illegally supplied prescription drugs. The provisions contained within this chapter should be read in conjunction with procedure and guidance contained within [Chapters 2](#) and [Chapter 7](#) of this instruction.

### Classification of Drug Related deaths

Fatal outcomes linked to adverse drug reactions can occur in a number of circumstances:

- Poisoning or accidental overdose;
- Suicide;
- Homicide.

### The Role of the Police and HM Coroner in Drug Related Deaths

Police have responsibilities in circumstances where it is possible that an offence has been committed in the circumstances surrounding a drug related death.

In addition to providing information and evidence to enable the Coroner to fulfil their obligations, police have a responsibility to secure and preserve evidence of any criminal offence connected to the person's death.

For the purpose of this chapter, this will include criminal offences related to the supply of illicit or prescription drugs. A drug related death may be treated as 'non-suspicious' or 'suspicious' (see also [Chapter 2](#)).

All deaths, including suicide, that are suspected of being caused by illicit drugs (or the illegal supply of prescription drugs) will be treated as 'suspicious'.

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<sup>1</sup> For the purposes of this chapter, the term 'illicit' refers to drugs forbidden by law, and unlawful activities concerning the importation, production, or supply of controlled drugs. Interpretation may be extended to include drugs which as yet remain unclassified e.g. so-called 'legal highs'.

### Procedure on attending a Suspicious Drug Related Death

The term 'suspicious' refers to any circumstances where an officer believes or suspects, that death may have occurred due to a criminal act (e.g. criminal homicide). For the purposes of this chapter, it also includes circumstances where the illegal supply of drugs may be connected to the death. Specific procedures relating to the investigation of suspicious drug – related deaths are outlined in the following paragraphs.

#### First Officer at the Scene

The responsibility of the first officer at the scene of a suspicious drug related death is to:

- Preserve life (summon medical assistance if appropriate);
- Task an FMO to pronounce death;
- Establish and maintain the scene (as per SI 'Duties of Personnel attending a Serious Crime Scene') to maximise the collection of relevant evidence and intelligence;
- Make initial enquiries to ascertain the facts and circumstances surrounding the death. This includes enquiries concerning

the supply of drugs to the deceased, where appropriate;

- Ensure, where relevant, that the harassment, domestic abuse and child protection registers are examined;
- Ensure the death has been reported to the Coroner by telephoning **0300 200 7811**;
- In the case of a suspicious drugs related death of a child under 18 years of age, or any concern of a child protection nature, a referral should be made as soon as possible to the Health & Social care Trust or regional 'Out of Hours' service, as per the 'Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland' ([Click here](#));
- Consider any potential drug related risk posed to others e.g. children in the household or living elsewhere.

The first officer at the scene should not terminate duty unless spoken to by Detectives or released by the SIO.

#### Scene Preservation

As far as possible, the scene should not be disturbed until the facts surrounding the death have been established. In order to

preserve evidence, the body of the deceased should not be removed until the investigations at the scene are complete, or as directed by the SIO.

A Serious Crime Scene Log (Form 38/15) should be opened and the integrity of the scene preserved.

Full forensic protection will be required within the scene area.

Scene Log Officers should consult with the senior officer at the scene in relation to requests to enter the scene e.g. a priest wishing to administer last rites. All such requests will be considered individually, and if a decision is made in the affirmative, full forensic protection will be required.

Appropriate health and safety precautions should be observed with regard to the presence of suspected drugs, syringes and other drugs paraphernalia.

Once the body is removed, the scene should be searched by search trained officers, in Personal Protection Equipment, for evidence of drugs or other criminality. All seizures should be fully documented on Form 38/15 and packaged in accordance with Service instructions.

Where the body is that of a child under the age of 18, the 'Protocol for Joint

Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland' must be complied with.

### **Police required to attend the Scene**

In addition to the first officer responding, a Sergeant must attend the scene of every death.

A ROC Detective Sergeant should be tasked to the scene of a suspected drug related death.

The ROC DI should be consulted where the ROC Detective Sergeant believes the death is suspicious. During this consultation, the DI should satisfy themselves that the scene is being managed and that all appropriate lines of enquiry are being followed. The DI should consider attending the scene and where they decide that it is unnecessary to do so, they will record the reason for that decision. The DI will also give consideration as to whether a drug expert should be tasked to the scene. Where they believe this to be unnecessary, the reason for their decision should be recorded.

Where the ROC DI confirms that the death is to be treated as suspicious, the on-call MIT SIO shall be tasked through the call-out desk at UCMC. In cases of doubt, the advice of a MIT SIO should be sought. In

the case of every suspected death by illicit or illegally supplied prescription drugs, the ROC DI should also advise the on – call C1 SIO via UCMC call-out desk and seek advice. The C1 on-call SIO will assist in the provision of a drugs expert who, at the request of the ROC DI, will also attend the scene as required.

A CSI should attend a suspicious drug related death for the identification, recording and recovery of potential evidence which may require scientific analysis. This will include circumstances where death occurs in a hospital, Prison or in other specific circumstances. In any drug related death, if a Higher CSI is available, they should be used although it is recognised that, due to staffing levels, this may not be possible.

Photography Branch should attend a suspicious drug related death and record photographs of the scene under the direction of the SIO, IO, or specialists acting on their behalf.

If there is a suspicion of criminal homicide (i.e. murder or manslaughter) by illicit or prescription drugs, consideration should be given to the attendance of other agencies e.g. mapping. The contribution of a forensic pathologist to the criminal investigation of a death is often crucial to achieving a positive

outcome, and their involvement should be considered at the earliest stage of an enquiry.

Where such involvement is sought, the SIO will ensure that a forensic pathologist is fully briefed and involved in the investigative process. Where there is a request for a pathologist to attend the scene, the crime scene manager, on behalf of the SIO, will enable a suitable working environment for the pathologist.

The scene of a suspicious drug related death will remain open until after the post mortem has taken place. Where locking and securing a scene are an option, this decision will be made at the discretion of the SIO.

### **Removal of Remains**

A full forensic post mortem will be required for all suspicious drug related deaths (see [Chapter 2](#) for guidance on removal from the scene).

At the scene of a suspicious drug related death (including deaths in hospital), CSI personnel will place the remains in a body bag, seal it with a numbered tag and photograph the seal.

The Northern Ireland Regional Forensic Mortuary (NIRFM) will be used for all suspicious drug related deaths.

The decision to close the scene should only be taken by the SIO once preliminary findings of a PM are known and scene examination is complete.

### **Investigations**

The police will notify the Coroner about all drug related deaths (see [Chapter 2](#) 'Notify Coroner').

Where it has been concluded that a drug – related death is not to be classified as suspicious, the Sergeant in charge will appoint a uniform officer, usually the first officer attending the scene, to inform the Coroner, attend any post mortem and revert to the relevant Case Progression Team for preparation of an Inquest file (if appropriate).

In cases of suspicious drug related deaths, where criminal homicide has been excluded, the ROC Detective Sergeant will lead on the investigation into the supply of drugs, appoint an IO from ROC, and ensure completion of the inquest file.

In cases of suspicious drug related deaths, where criminal homicide is suspected, a MIT SIO will oversee the investigation and completion of the inquest file.

In cases where a death has initially been classified as non-suspicious but where subsequent investigations indicate that illicit drugs (or illegally supplied prescription drugs) were the cause of death, the procedures and responsibilities above will apply.

If the death is suspicious, drug related and appears to be suicide by overdose, a form SD1 should be submitted.

### **Attendance at Post Mortem**

A full forensic post mortem will be required for all suspicious drug related deaths.

The completion of Form 19, Form P1 and other guidance concerning attendance at a post mortem is contained in Chapter 2.

The IO/SIO, or an officer appointed by the IO/SIO should attend the post mortem concerning a suspicious drug related death. The pathologist should be advised that an investigation into the suspected illegal supply of drugs has been initiated. In addition, the officer in attendance should brief the pathologist on the layout of the scene, the circumstances in which the deceased was found, the result of initial enquiries and any areas of concern. See also Chapter 2 'Briefing the Pathologist'.

Every effort should be made to ensure that photographs and drugs or other evidence

from the scene are brought to the post mortem.

Guidance on the completion of the post mortem examination log (Form P3) can be found in Chapter 2.

In addition, any samples taken at the post mortem requiring to be examined at by FSNI need to be submitted ideally within 48 hours but definitely no later the 10 days after the post mortem. Please liaise with your District property manager in relation to barcoding samples, logging them on NICHE property and transporting them to FSNI.

### **Where the Death is No Longer Deemed Suspicious**

Following a post mortem into a suspected suspicious drug related death, where the pathologist is of the opinion that:

- the death was due to natural causes; or
- the death was drug related, but after due consideration the DI/SIO are satisfied that the circumstances are unrelated to criminal activity by a third party, illicit drugs or the illegal supply of prescription drugs; further investigation will be conducted by a uniform officer on behalf of the Coroner.

This decision and supporting argument must be recorded on NICHE. The

investigation will be returned to a uniform officer/Case Progression Team by agreement of the SIO, ROC DI and District Duty Inspector.

The Coroner's Service must be informed, at the earliest opportunity, that the death will be investigated by police, on behalf of the Coroner. A comprehensive CSR of the investigation to date (incorporating all relevant documentation) should be completed by the allocated Detective and handed to the appropriate Duty Inspector.

The relevant NICHE log and Command & Control entries must be updated by ROC to indicate that the death is no longer considered suspicious and that investigative responsibilities have reverted to a named uniform IO/CPT.

### **Where a Death Remains Unexplained following Post Mortem**

For investigative purposes, deaths classified as suspicious at the outset will be treated accordingly until the contrary is shown (see Chapter 2). Where a death has been initially treated as non-suspicious, but toxicology results and/or other evidence or intelligence subsequently indicate a suspicious drug related death, the provisions contained within this chapter will apply.

**Concerns of a Suspicious Drug Related Death arising during a Post Mortem into a Death treated as Non-Suspicious**

Under these circumstances, the post mortem should be suspended and the ROC DI should be informed. The ROC DI will collaborate with the on-call SIO.

Where applicable, the SIO will be responsible for the deployment of any Scientific Support resources prior to the resumption of the post mortem. In these circumstances, a new post mortem examination log (Form P3) should be commenced.

Following a post mortem where the DI is of the opinion that a drug related death is suspicious, it should be treated as homicide until such times as the contrary is established.

**Review**

The DI/SIO should set the investigation plan and self-review the investigation (including the drug supply aspect) within 2 weeks of commencement and continue to review every 4 weeks thereafter. The District Crime Manager should consider requesting a peer review of the investigation when appropriate.

Each District should create an RM occurrence log for all drugs related deaths to ensure that investigative links are

identified and exploited at the earliest opportunity.

**General Advice & Guidance on Initial Assessment at the Scene**

Drug related death may involve illicit or prescription drugs either causing or contributing to death and death may occur through a single substance intoxication; multi-substance abuse (including alcohol); a fatal adverse drug reaction involving medication; several routes of administration including oral, intravenous, insufflation, sublingual or rectal or from infectious diseases transmitted through the sharing of drugs paraphernalia. Therefore, in light of these variables and the accompanying complexities of scene interpretation, the following advice and guidance is not intended to be prescriptive.

**Drug Related Deaths Investigated as 'Non-Suspicious'**

Where the Duty Sergeant and ROC Detective Sergeant in attendance at the scene concur in their initial assessment that a drug related death was not connected to a criminal act or the supply of illicit drugs or illegally supplied prescription drugs, the death may be treated as 'non-suspicious', and investigated accordingly. (Where consensus cannot be reached, the advice of the ROC DI should be sought.)

Such circumstances may include over-the-counter drug related overdose; fatal adverse drug reaction or overdose related to legally prescribed medication (e.g. tricyclic antidepressants, temazepam, diazepam, and methadone) or suicide through legally held prescription drugs where there is no suspicion of the involvement of another party.

### **Drug Related Deaths Investigated as ‘Suspicious’**

As per the procedures and guidance contained in this chapter, all deaths, including apparent suicide, that are suspected of being caused by a criminal act (including the supply of illicit drugs or the illegal supply of prescription drugs) will be treated as suspicious and investigated accordingly.

Examples may include evidence of illicit drug related overdose; evidence of overdose related to the illegal supply of prescription drugs; evidence of injecting an illicit drug prior to death; the presence of drug paraphernalia at the scene or information or intelligence to suggest that the deceased had ingested illicit drugs in the time prior to death.

## 7. The Removal, Retention and Use of Human Tissue

### Definition of Human Tissue

The Human Tissue Act 2004 defines human tissue to include the smallest of tissue samples, including blocks and slides.

For ease of reference human tissue is classified as follows:

Class 1 – material taken at the post mortem examination which would not generally be considered part of the body (e.g. nail and hair cuttings, blood, urine, buccal swabs, gastric contents etc.);

Class 2 - samples of human tissue which are not a significant part of the body (e.g. small tissue samples, blocks, slides etc.);

Class 3 – samples of human tissue that incorporate a significant part of the body (e.g. organs, limbs etc.).

### Powers of seizure

#### Pathologist

The pathologist has the authority to take, retain and dispose of human tissue on behalf of the police and the Coroner.

#### Coroner

The power of seizure and retention for the Coroner is defined in the Coroner's Act (NI)

1959 and the Practice & Procedures Rules 1963.

### Police

PACE - All human tissue seized from the body must be taken under Article 21 of the Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE). Power of Retention - all material seized under Article 21 of PACE will be retained by or on behalf of the Police under Article 24 of PACE.

### Reasons to Retain Human Tissue

Reasons to take samples for the Coroner:

- to assist with identification of the deceased; and
- to determine a cause and circumstances of death.

Reasons to take samples for the PSNI:

- to assist with identification of the deceased;
- to determine a cause and circumstances of death; and
- for evidential purposes where a crime is suspected.

### State Pathologist's Department (SPD)

Samples of human tissue taken by the pathologist in routine non-suspicious deaths will be taken using Coroner's

legislation and therefore will not be exhibited by police.

Samples of human tissue taken by the pathologist in suspicious deaths will be taken using police powers of seizure and recorded within post mortem examination log, Form P3 and listed on the C1a.

### **Exhibiting and Recording of Human Tissue**

Where a death is considered to be suspicious or confirmed homicide, all samples taken by the pathologist on behalf of the police (i.e. under PACE) will be allocated with an exhibit reference number and have a NICHE property barcode attached.

Details will be recorded within the Form P3 and on the C1a. Items such as tissue samples, certain bodily fluids and organs, which will be examined at the State Pathologist's Department or non-FSNI laboratories, will be exhibited and handed back to the pathologist and the continuity recorded to maintain the evidential integrity of the exhibit.

### **Submission of Items to FSNI**

All items handed to the IO or SIO's representative by the pathologist for examination other than in the State Pathologist's Department must be delivered promptly to the FSNI in

accordance with current Service Guidelines. Please note that any delay in submitting samples can delay the release of remains from the mortuary if identification is an issue.

Samples taken at post mortems requiring to be examined at FSNI e.g. blood, urine and stomach contents for alcohol and toxicology need to be submitted ideally within 48 hours but definitely no later than 10 days after the post mortem. These samples would be particularly important in drug related deaths (See [Chapter 6](#)).

Property managers should note that under no circumstances should class 2 or class 3 human tissue sample taken during a post mortem be stored on police premises. Such items should only be on police premises as a temporary measure when being transferred to FSNI or being returned to the State Pathologist's Department.

All items of human tissue retained by or on behalf of the police must be recorded on NICHE as soon as practicable.

All class 2 and class 3 human tissue samples not at FSNI for examination must be returned to State Pathologist's Department for storage.

### **Review of Requirement to Retain Human Tissue**

Human tissue must only be retained when legally required and the rationale recorded. As all human tissue will be recorded on NICHE. A review at 3 months will be set by the CSI. Once the SIO / IO has carried out this initial review they should set subsequent review periods as they deem fit in line with their investigation until the human tissue is no longer required for the investigation.

Retention of human tissue (and related communication with NOK) will also be considered on the Agenda of Peer Support Groups, 28 day reviews and subsequent reviews in all homicide cases.

The SIO, upon completion of the investigation re suspicious death or homicide, is required to convene a meeting, which should include relevant agencies (Coroner, Pathologist, PPS etc.), and fully debrief and record the decision on the requirement for continued retention of any human tissue samples.

Police will not store human tissue on police premises other than as a short-term transit location whilst going to/from FSNI, SPD or other laboratory facility.

### **Method of Disposal of Human Tissue**

When a death has initially been investigated as suspicious, but subsequent enquiries have explained the cause of death and negated any original suspicions, the police investigation will cease but the investigation on behalf of the Coroner will continue.

In the unusual circumstance that the Coroner does not wish to invoke Coronial powers of retention, and the human tissue is no longer required by police, the police must immediately have this disposed of following the procedure outlined below.

### **Transfer of Human Tissue to Coroner's Legislation**

When items of human tissue are no longer required by the police investigation, the Coroner must be informed. The IO should submit Form 106 (Letter to Coroner-human tissue), outlining the case, the material held, and the location of each item to their OCMT for inclusion on NICHE and onward transmission to the Coroner's Office.

The Coroner will respond outlining if they wish to invoke Coronial powers of retention or otherwise.

All items which require submission to FSNI must still be submitted as advised or requested by the pathologist.

When the Coroner indicates that they are invoking Coronial powers of seizure, the State Pathologist's Department must be informed by telephone and all locally held samples must be transferred to SPD at the earliest opportunity. Property staff must ring ahead and book an appointment to attend with the samples and also take a copy of the signed Form 106 with them

Records must be perfected outlining the actions taken i.e. NICHE tab must be amended to "disposed" and OEL must be updated to the effect that disposal has been carried out by powers of retention changing to and now the responsibility of the Coroner.

### **Disposal of Human Tissue**

Where it is identified that human tissue retained using police powers during an investigation is no longer required and the Coroner having responded to Form 106 (letter to Coroner re human tissue) that Coronial powers are not being invoked (not required by Coroner) the following disposal method must be followed:

- It should be established with the Coroner's Office whether the NOK have previously indicated their wishes in respect of human tissue retained. If not, they should be consulted by the FLO, where appointed, or the IO to indicate their

preferred method of disposal (repatriation, cremation, dignified disposal) on Form P5;

- The response from the Coroner (stating that their office does not require the human tissue) and completed Form P5 must be promptly forwarded to SPD;
- The State Pathologist's Department will dispose of human tissue (cremation or dignified disposal) or return the specimens to the family via an undertaker appointed by them for repatriation as per the wishes of the next of kin and following instruction from the police and the Coroner that neither requires the item;
- The NICHE tab must be amended to "disposed" and OEL must be updated to reflect same.

### **Overview of Human Tissue Management**

Head of Justice Branch will quality assure the Service's holdings of human tissue on a bi-annual basis.

An audit will be conducted twice yearly and results reported to Head of Legacy and Justice Department.